EDUCATION DEPARTMENT (ED)

Contingency and Relief Measures for the Secondary School Places Allocation Exercise 2001

Background

This direct investigation was initiated in the wake of widespread community and media criticism over the contingency and relief measures implemented by ED after the Court ruling in June 2001 that the Secondary School Places Allocation ("SSPA") System was sex discriminatory and unlawful. We examined whether ED had implemented these measures fairly and reasonably and handled banding information of students properly.

Contingency and Relief Measures

2. ED had made the following administrative arrangements for implementing its contingency and relief measures –

Contingency plans

(a) Enhancement of the SSPA computer system commenced in November 1999 and was completed in May 2000 in readiness for the SSPA exercise 2000. In March 2001, ED drew up a contingency plan to prepare for a possible unfavourable Court ruling.

Relief Measures

(b) In anticipation of the Court not ordering immediate removal of the gender-based features of the SSPA System, ED started planning for Relief Measures ("RM") in early June 2001. Guiding principles and criteria for determining the affected students were devised. Special computer programme was designed. 3,500 extra Secondary One ("S1") school places were reserved for affected students.

(c) During the press conference to announce the RM, ED stressed that vacancies available for placement under the RM would only be 600 and that successful re-allocation would be extremely limited.

(d) ED received 7,722 applications under the RM, identified 3,001 students as affected and placed 2,261 to schools of their higher choice. The remaining 740 students were not re-allocated due to lack of vacancies. The RM exercise was completed in two weeks.

Special Placement Service

(e) For the 740 students, ED offered Special Placement Service ("SPS"), a measure "outside the RM", in an additional S1 class in ten Government and one aided secondary schools. This successfully placed 672 students; the remaining 68 did not seek special placement.

Monitoring Group

(f) To enhance transparency and fairness, ED set up a Monitoring Group ("MG") to oversee and, where necessary, to advise on operation of the RM. The MG, comprising seven appointed non-official members, held five meetings.

Banding information

(g) ED did not disclose banding information to individual students and did not retain such information after the SSPA exercise. However, ED could, if necessary, manually re-calculate from internal raw data and schools' scaling curves.

Observations and Opinions

3. The Ombudsman made the following observations and opinions –

General comments

(a) The allocation of S1 places in 2001 was complicated by simultaneous education reform : abolition of the Academic Aptitude Test and reduction of bands from five to three. The latter resulted in a greater degree of randomization and unpredictability in allocation, thus greater dissatisfaction among parents and students.

(b) Time constraint and parental pressure aggravated the strain on ED. At times, ED staff had to work round-the-clock to meet the tight schedule.

Contingency plans

(c) ED was technically ready for combined processing in the 2000 and 2001 SSPA exercises. ED had prepared for contingencies.

Relief measures and special placement service

(d) ED's assertion that SPS was "outside the RM" was not convincing. It was clearly devised to accommodate the remaining affected students not placed in schools of their higher choice under the RM. The SPS was, therefore, *de facto* an extension and an integral part of the RM.

(e) Had ED assessed more accurately the number of affected students and included in the RM exercise the additional school places later created under the SPS, placement would have been, and could be seen as, better co-ordinated.

Operation of the monitoring group

(f) ED did not allow enough time for the MG to comment or to advise before the results of the RM were made public.

(g) The fourth meeting of the MG was held with more than half the members absent.

Handling of banding information

(h) ED's practice of not retaining students' banding information after allocation was unreasonable, given the importance of the band in determining priority for placement and the justifiable need for students/parents and investigating bodies, such as the Equal Opportunities Commission ("EOC") and this Office, to inspect such information in case of queries or complaints.

(i) As ED could reconstruct banding information from raw data, it could be argued that the department was still holding banding information indirectly. ED should review its practice of not retaining and not releasing banding information to students/parents on their express request, to ensure consistency with the Personal Data (Privacy) Ordinance.

Public announcements and comments

(j) Some parents had refrained from applying for relief due to ED's statement at press conference about the slim chance of success. They then found that statement to be untrue: ED had practically re-allocated all affected students through the RM and the SPS. Those speculative utterances had come across as cautioning against application for relief.

Other observations

(k) ED had reviewed the SSPA System and announced in December 2001 that, to abide by the Court ruling, the only changes for the time being would be removal of the gender-based features.

(l) ED had released in February 2002 new guidelines for internal assessment of Primary Five and Six students.

(m) The Education Commission would further review the SSPA System in 2003/04 and any long-term changes would be implemented in 2005/06.

Conclusions

4. The Ombudsman made the following conclusions –

(a) ED had prepared for contingencies.

(b) The relief measures were fine in principle but deficient in implementation.

(c) Administrative deficiencies had been identified in the procedures for the MG's execution of its advisory and supervisory functions.

(d) ED's treatment of requests for access to banding information from EOC and from aggrieved students or their parents was inconsistent.

(e) ED had made apparently "cautious", but in effect misleading, statements about the chances of success under the RM.

(f) Introduction of the SPS, in our view a *de facto* extension of the RM, had been made with undue haste and without advance notice to students and parents.

Recommendations

5. The Ombudsman made the following recommendations to ED –

Relief measures

(a) To ensure fairness and maximum access to redress for affected students when formulating and implementing RM, if ever necessary again in future.

Monitoring mechanism

(b) To work out with the monitoring body beforehand the key stages of operation and set up corresponding check points for review.

(c) To allow time for the monitoring body to review and advise on the operation and for the department to respond to or act on such advice.

(d) To reschedule meetings of the monitoring body when more than half of the members are absent.

Banding information

(e) To review, in consultation with the Office of the Privacy Commissioner for Personal Data and EOC, the existing practice of retaining and releasing banding information.

Public announcements and comments

(f) To refrain from speculating on success of appeal in public statements or comments.

Long-term allocation

(g) To speed up the progress of the overall review of the SSPA System.

Final Remarks

6. The Ombudsman saw a conflict between the policy objectives of the Sex Discrimination Ordinance and the educational principles behind the SSPA System. While the legislation on sex discrimination should be enforced, we also saw the need to recognise and accept the different rates of growth, development and maturity between boys and girls. This was a fact of life and nature which no legislation could alter.

May 2002

HOME AFFAIRS DEPARTMENT (HAD)

The Role of HAD in Facilitating the Formation of Owners' Corporations

Background

In April 2001, Government announced a comprehensive strategy on building safety and timely maintenance. This included responsible building management, for which HAD was given considerable extra resources to promote and encourage.

2. Meanwhile, there was considerable public concern over HAD's role in facilitating the formation of Owners' Corporations ("OCs") in private buildings. This investigation examined the means and mechanism of HAD for assisting property owners in OC formation, ascertained their adequacy and effectiveness and assessed the need for improvement.

Government Policy

3. Responsibility for managing and maintaining private property rests with the owners. The role of Government is to assist and support responsible owners and to take action against non-compliance. Government's established policy on private building management is to encourage property owners to form OCs and to advise and assist them in carrying out their responsibilities.

Means and Mechanism for Assisting Property Owners

4. Four Building Management Resource Centres ("BMRCs") were set up in Kowloon, Hong Kong, New Territories West and New Territories East to provide information and advice for owners; to organise training courses and workshops for them; and to mount exhibitions on building management. BMRCs also arranged appointments for free expert advice by seven professional bodies upon the request of owners and OCs.

5. With the additional resources, HAD set up a Building Management Division ("the Division") in Headquarters to take charge of the overall planning and co-ordination of building management functions and services. The Division also provided support to staff in districts. District Building Management Liaison Teams ("Liaison Teams") were set up in the 18 District Offices ("DOs") to assist owners to form OCs, to provide outreach support service to OCs and owners, to attend OC meetings, to handle complaints and to mediate in disputes. Liaison Teams were staffed by Liaison Officers, Housing Grade Officers and Temporary Community Organisers ("TCOs"), varying in numbers according to district needs and workload.

6. HAD supported frontline staff by publishing reference manuals, advising on difficult cases and equipping them with the necessary knowledge and skills. The Department promulgated appropriate guidelines and procedures for control of service delivery, held regular staff meetings, set performance indicators and targets and regularly reviewed its services.

Conclusions

7. From the investigation, this Office formed the following conclusions –

(a) There was scope for HAD to improve the means and mechanism for delivering services on OC formation.

(b) HAD staff would benefit from clearer guidelines and procedures on services for OC formation.

(c) HAD staff should be more professional and proactive in assisting owners in OC formation.

(d) HAD's overall efficiency and effectiveness in OC formation services could be raised if (a) to (c) above were properly addressed.

Recommendations

8. The Ombudsman made the following recommendations to HAD –

Means of service delivery

(a) To produce a comprehensive information-cum-resource kit including VCD on OC formation for reference of owners and those who wish to form OCs.

(b) To improve the website on building management by adding a thematic section and a sitemap for ready retrieval of information.

(c) To seek client feedback and review the opening hours of BMRCs to suit client convenience.

(d) To enhance the telephone enquiry and advisory service for client convenience.

(e) To enrich the contents of reference manuals, and to publish categorised case studies of good practice and summaries of court judgments on building management cases for staff reference.

(f) To produce information materials, such as leaflet and poster, on the criteria, limitations and procedures of the free professional advisory service.

(g) To identify and review operations essential to the delivery of services on OC formation, draw up appropriate criteria, guidelines and procedures for these operations and suitably promulgate them among staff.

(h) To consider the scope for simpler, less formal and less costly mechanism for resolving building management disputes.

(i) To expedite the production of a clear and comprehensive pamphlet to publicise building management services.

(j) To publish a central building management bulletin or newsletter to disseminate to the public up-to-date building management information and services.

(k) To organise and conduct more talks with OC formation as the main theme.

Support and control

(l) To provide support for frontline staff by professional advisory service in a more systematic manner.

(m) To strengthen staff training on customer services, communication and mediation skills as well as training on the Building Management Ordinance and other building management issues.

(n) To include more performance indicators to better reflect efforts on OC formation and to set out corresponding targets to better monitor staff performance.

(o) To regularly publish performance targets and achievement on OC formation services for improved transparency and accountability.

(p) To set up client liaison group(s) to tap client feedback and suggestions for service improvement.

(q) To tap the local knowledge of District Councils for views on strategies, priorities, targets and feedback on the work and performance of Liaison Teams.

Organisational set-up and staff deployment

(r) To rectify the situation in some DOs where Liaison Teams exist nominally but not in practice.

(s) To review and revise the duties of TCOs.

Others

(t) To consider amending the law to empower the Department to investigate into complaints alleging non-compliance with the legal requirements for OC formation.

(u) To review critically, in consultation with stakeholders, the Department's role and services in building management.

9. Overall, HAD accepted all recommendations in the report. The Department had also started to implement a number of similar measures in the course of our investigation.

March 2003

HONG KONG SPORTS DEVELOPMENT BOARD (SDB)

Funding of Sports Programmes by SDB

Background

To ensure that public funds granted to National Sports Associations ("NSAs") for development of sports were allocated and monitored fairly and efficiently, The Ombudsman conducted an investigation into the funding of sports programme by SDB.

Funding Allocation Process

2. The procedures were as follows –

(a) Each NSA would submit to SDB a "Yearly Plan" detailing breakdown of expenditure.

(b) The Sports Development Manager ("SD Manager") concerned would check every item in accordance with SDB guidelines, to arrive at a preliminary budget for each NSA.

(c) All SD Managers would meet to adjust the preliminary budgets to the level within SDB's overall projected provision.

(d) The Executive Director, Sports Development Committee, Hong Kong Sports Institute Management Committee and Corporate Management Committee cleared the revised budgets for the approval of the SDB governing body.

Monitoring and Control

3. SDB monitored NSA's subvented activities as follows –

Plans and reports

(a) To justify allocation of subvention, every NSA had to submit an annually updated Four-year Plan, Yearly Plan, Programme Plan and an Annual Financial Report. For every subvented programme, the NSA had to furnish an Application for Grants, a Statement of Accounts and an Evaluation Report.

Meetings and visits

(b) SD Managers regularly met with NSA officials, visited NSAs at least 15 times a year, attended their sports events, executive committee meetings and annual general meetings.

Monitoring subvented staff

(c) For posts funded by SDB, SD Managers participated at staff selection interviews, took part in staff training, scrutinised staff appraisal reports and interviewed the staff regularly.

Comments and Opinions

4. The Ombudsman made the following comments and opinions –

Funding policy

(a) The funding policy should be realistic and rational, comprehensive and comprehensible. It must be made clear to all parties concerned.

Funding allocation practices and procedures

(b) SDB appeared to apply the funding policy too rigidly, thereby discouraging NSAs from attempting new or creative projects.

(c) On the funding allocation process –

i) NSAs tended to exaggerate events and participants in their funding applications, wasting SD Managers' time and efforts in vetting;

ii) if NSAs were given a budget to work on and advised of the allocation criteria before drawing up their Yearly Plans, they could tailor their bids accordingly; and

iii) SDB's criteria for scrutinising NSAs' requests appeared to be unreasonable at times.

Monitoring system

(d) On SDB's monitoring of NSAs –

i) the application procedures were cumbersome, some details had to be supplied repeatedly;

ii) some supporting documents and forms might not serve any useful purposes;

iii) when irregularities were detected, remedial measures to be taken by NSAs concerned were not monitored; and

iv) some control measures were too severe and might have undesirable effects.

Conclusions

5. While there should be proper control of public funds, the present system was cumbersome, rigid and unreasonable on occasions. It gave the impression of a lack of mutual trust between SDB and NSAs.

6. We noted that the Home Affairs Bureau had published a consultation report "Towards a More Sporting Future" to simplify procedures on funding of NSAs in June 2002. We supported the proposals and hoped that our findings and recommendations would help the review.

Recommendations

7. SDB accepted the following recommendations from The Ombudsman –

(a) **Long term measure** – a revised system should be introduced for the efficient management and monitoring as well as effective use of public resources.

(b) **Interim measures** –

Allocation of grants

i) review the allocation criteria;

ii) updating the guidelines on funding allocation;

iii) NSA officials responsible for assessing applications should be fully conversant with the policies and procedures, practices and guidelines;

iv) NSAs should have adequate information and advice to enable them to prepare the Yearly Plans rationally and realistically;

v) funding policy and guidelines should be interpreted liberally and flexibly with due regard to the expertise of NSAs in their specific fields;

Monitoring

vi) streamlining the present scale of plans and reports required for the submission;

vii) review the application forms;

viii) devising a system to ensure that NSAs would take follow up action on SDB's requests and suggestions; and

ix) amending monitoring measures that impose unduly harsh sanctions.

August 2002

HOSPITAL AUTHORITY (HA)

Handling Missing Patients in HA Hospitals

Background

This direct investigation was initiated following reports of patients missing from HA hospitals. We examined the administrative procedures and practices for handling in-patients reported or found missing from HA hospitals, ascertained their adequacy and effectiveness and assessed the need for improvement.

Missing Patients

2. Between June 1999 and May 2001, there were 6,486 reports of patients missing from 40 HA hospitals. In nine cases, the patient was later found dead.

Reasons for Missing

3. A hospital is for medical treatment and recuperation, not for detention, of patients. Patients, therefore, have unrestricted movement within the hospital compound. Patients often leave their ward. There were many reasons for patients going "missing" from hospitals – e.g. to attend to personal matters, to have tea or other recreational activities with friends, to get illicit drugs and to leave upon regaining consciousness from drunkenness or drug overdose.

Hospital Responsibilities and Patient Responsibilities

4. HA hospitals are responsible for the safety and well-being of patients in their care, particularly those "at risk". In turn, patients had responsibility to follow hospital rules for patient conduct. HA expected patients, and their families, to abide by hospital rules and regulations.

Guidelines and Procedures

5. HA adopted an approach of decentralised management, with Hospital Chief Executives being responsible for the management of their hospitals. In 1995, HA issued guidelines on procedures for handling missing patients, with suggestions such as searching for them, contacting family members/relatives, reporting to the medical officer on duty, recording the incident and notifying the Police.

Practices

6. A patient is free to move within hospital premises and was often encouraged to do so to facilitate recuperation. HA hospitals would monitor the movement of patients through checks by nurses before medication/treatment and during meal times, head count before handing over to the next shift and ward rounds by medical officers.

7. When a patient was found or reported missing, hospitals would activate their operational guidelines and procedures. These were not identical for all HA hospitals.

Observations and Opinions

8. From our investigation, we had some observations and views –

Definition

(a) HA hospitals had devised four definitions based on their perception and experience of handling patients found or reported missing. Different hospitals adopted different definitions, resulting in inconsistency and inaccuracy of information.

Method of counting

(b) Lack of uniform counting was the result of diversity in definition and interpretation of "missing patients". Some counted "episodically" and others "individually".

Reporting to police

(c) HA guidelines, issued in 1995 and 1999 respectively, had guidance on seeking Police assistance. The decision whether or not to report to the Police would be for the staff concerned to make, based on their clinical judgement and assessment of the patient as well as the circumstances at the time.

Closing cases

(d) There was no uniform timespan to close "missing patient" cases. Some hospitals used as benchmark 24 hours or 48 hours.

Keeping statistics

(e) The two sources of "missing patient" data – HA's computerised data warehouse and hospitals' manual records showed substantial discrepancies. For the same period between June 1999 and May 2001, the computerised data warehouse captured 2,992 cases and the manual records 6,486 – a difference of 3,494.

Preventive measures

(f) HA maintained that there should be a balance between monitoring patient movement and respecting patients' personal freedom and rights. Hospital staff would exercise their clinical judgement in implementing appropriate measures to minimise the risk of patients disappearing from hospitals.

Patient and family responsibilities

(g) Patients and family were also responsible for reducing the risk of patients missing from hospitals. They should cooperate by complying with hospital conditions, rules and regulations.

Conclusions

9. This Office had the following conclusions –

(a) There was no standard definition of "missing patients" for adoption HA-wide.

(b) There was no uniform method of counting missing patients HA-wide.

(c) There was no uniform practice among HA hospitals in reporting missing patients to the Police.

(d) There was inconsistency in missing patient data and records maintained by HA Head Office and individual hospitals.

(e) There were no guidelines on procedures for hospital staff to take suitable measures for minimising the risk of patients disappearing from hospitals.

Recommendations

10. The Ombudsman made 14 recommendations to HA –

Definition and method of counting

(a) To standardise the definition of "missing patient" among HA hospitals.

(b) To devise a formal definition of patients "at risk" to enable staff of all HA hospitals to take appropriate precautions.

(c) To standardise the method of counting missing patients among HA hospitals.

Handling of missing patients

(d) To review and update HA guidelines and procedures for handling missing patients and to require HA hospitals to put in place operational instructions for application.

(e) To standardise the procedures and practices HA-wide for reporting cases of missing patients to management and to family.

(f) To examine the existing measures taken by hospital staff in minimising the risk of patients disappearing and to formulate relevant guidelines and procedures.

(g) To enhance staff awareness and vigilance in handling patients "at risk".

(h) To enhance guidance for patients and family to impress upon them the need for compliance with hospital rules and regulations.

(i) To review and update the guidelines on seeking Police assistance after a specified time span, say, 24 hours after disappearance (as usual for Police cases) and less for patients "at risk".

(j) To standardise the procedures and practices HA-wide for reporting cases of missing patients to the Police for assistance.

(k) To standardise the time span for closing a case –

  (i) after thorough search; and

  (ii) report to the Police.

Management information

(l) To introduce measures for accurate and consistent management information on missing patients.

(m) To designate a unit in HA Head Office to coordinate and collate records of missing patients.

Review

(n) To review arrangements for handling missing patients regularly and to revise them when appropriate in the light of changing circumstances and community expectations.

Final Remarks

11. HA saw eye to eye with this Office the community's legitimate expectations of HA taking proper precautions for the safe care of patients, particularly those "at risk". We were delighted that HA accepted all the recommendations and undertook to implement them fully in three to four months.

November 2002

SOCIAL WELFARE DEPARTMENT (SWD) AND TELEVISION AND ENTERTAINMENT LICENSING AUTHORITY (TELA)

Monitoring of Charitable Fund-Raising Activities

Background

Charitable fund-raising activities have long been a way of Hong Kong life. Considerable amounts of money are involved. There was community concern from time to time over the monitoring of such activities, especially whether the donations were responsibly used. This investigation examined the mechanism used by SWD and TELA for monitoring such activities, assessed the adequacy and effectiveness of such mechanism and areas for improvement.

Charitable Institutions

2. Some charities were established by legislation while a large number operated autonomously under their governing bodies. Many non-government charitable organisations were subvented and regulated by Government. Tax exemption was granted to charitable institutions or trust of a public non-profit making character.

Monitoring Mechanism

3. To maintain their operation, charities had to raise funds by public donations. Fund-raising in public places (mainly flag days) required a public subscription permit from SWD under the Summary Offences Ordinance. A licence from TELA under the Gambling Ordinance was required for fund-raising through lotteries. A permit or licence was not required for other fund-raising activities, e.g. auctions, balls, concerts, dinners, walks, film premiere, shows in mass media, request for donations by mail, advertisements or phone-in arrangements.

Limitations of the Law

4. SWD and TELA required from applicants, as a condition for approval, audited accounts of the fund-raising events. Both departments relied on these audited accounts to guard against unscrupulous use of the proceeds. However, SWD and TELA could not impose conditions *ad infinitum*. Moreover, these administrative conditions were confined only to specified fund-raising activities, not all the others which fall outside those Ordinances. Certainly, those organisations not holding events in public places or lotteries would not be subject to monitoring.

Conclusions

5. This Office had the following conclusions –

(a) Existing Government control of charitable fund-raising was confined to activities and not the organisations, and even then, only to flag days and lotteries.

(b) Control did not cover all charitable bodies or even all charitable fund-raising activities.

(c) Government monitoring of charities was partial and patchy, fragmented and ineffective.

(d) Present legislative provisions could not effectively safeguard the public against unscrupulous or irresponsible fund-raisers.

Recommendations

6. The Ombudsman had made the following recommendations –

For SWD and TELA

Short to medium term

Code of Practice

(a) To draw up a Code of Practice ("the Code") on good administration and management for reference of charities.

(b) To publish the Code for public information.

(c) In the light of (a) and (b), to review the need for imposing conditions on public subscription permit and lottery licence applicants.

Enhance transparency and accountability

(d) SWD to consider maintaining, for public inspection, a central register of charities which complied with the requirements of the Code.

(e) To display *in situ* annually the names of those charities for general information as a guide to their *bona fides*.

(f) To introduce a scheme for monitoring the *bona fides* of those charities seeking to be placed on the central register at (d), e.g. through complaints.

For the Administration

Longer term

(g) To review the adequacy and appropriateness of the present policy and practices on monitoring charities and their fund-raising activities.

(h) To consider the pros and cons of –

i) fuller Government control of charities; and

ii) reliance on charities self-regulating in line with world trend.

(i) To consider mechanism for deterring abuse and penalties for such acts.

7. SWD and TELA had accepted our recommendations for implementation in due course.

February 2003

TRANSPORT DEPARTMENT (TD)

Administration of Vehicle Registration Marks Auctions

Background

This direct investigation was initiated in the wake of reports that at auctions for vehicle registration marks ("VRMs"), the bullying behaviour of spirited gang members had calculated to deter other participants from bidding against their "boss". If unchecked, this could affect public confidence in VRM auctions.

Administrative Arrangements for Conduct of Auctions

2. TD adopted the following administrative arrangements for VRM auctions –

(a) **Auctioneers** – professional surveyors from within or outside Government.

(b) **Presiding executive** – while the supervisor in overall charge was a Senior Executive Officer, a junior Executive Officer of TD physically presided over the auctions. After the bullying incidents came to light, both the supervisor and a third officer would attend the auctions regularly.

(c) **Maintenance of order** – since November 2001, security guards have been engaged, liaison with the Police has been stepped up and plain-clothes police officers have been deployed to the auctions.

(d) **Rules governing the administration of auctions** – guidelines and instructions were issued to TD staff.

(e) **Notice on rules of etiquettes** – while not required to register, bidders and observers were issued with a copy of the notice on their entering the venue.

Observations and Opinions

3. The Ombudsman made the following observations and opinions –

Staffing

(a) In case of untoward incidents, the junior Executive Officer did not have sufficient experience, or the maturity, to take command of the situation.

On-site security guards

(b) They appeared to be either unacceptably lethargic or not suitably briefed about their role.

Maintenance of order

(c) Both the auctioneers and on-site TD staff took no action to maintain order in the venue and participants were free to move around while the auction was in progress.

Action against harassment

(d) Apart from making a report to the Police, TD staff and the auctioneers did not take any positive action to stop the harassing actions.

Recommendations

4. The Ombudsman made the following recommendations –

Staffing and guards

(a) A more senior and therefore experienced TD official should act as the auctioneer.

(b) TD should employ more professional guards.

Rules governing auctions

(c) TD should regularly review, update and re-print its guidelines and instructions.

(d) TD should consider pre-registration of bidders as common in other auctions, to help preserve their anonymity, thereby protecting them from being targets for bullying, and to prevent successful bidders from reneging on their bids by refusing to give their personal data.

(e) TD should strictly enforce the rule requiring participants to remain seated during an auction.

Measures against harassment

(f) TD should draw up clear directives on what constitutes harassing behaviour.

(g) The auctioneer should stop trouble-makers from continuing their harassing behaviour. In case of non-compliance, they should be escorted out of the venue.

(h) Should trouble-makers refuse to cooperate, the auctioneer should consider adjourning the auction. Police assistance should be enlisted when necessary.

(i) TD should reconsider the efficacy of video-taping the auctions.

(j) TD should explore alternative means to auction VRMs, for example, e-auctioning.

Public information and forewarning

(k) TD should widely publicise its rules and guidelines via the media, its homepage, information leaflets and its notice to participants.

Comments from TD

5. TD accepted most of the recommendations. However, TD preferred to continue with the employment of surveyors as auctioneers and agreed that they should be more experienced. TD also agreed to deploy experienced on-site staff to supervise the auctions.

October 2002